

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/15/2016
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVENUE TOPEKA, KS 66607		
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F 000	INITIAL COMMENTS	F 000			
F 201 SS=D	<p>The following citations represent the findings of complaint investigation #102856.</p> <p>483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT</p> <p>The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;</p> <p>The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</p> <p>The safety of individuals in the facility is endangered;</p> <p>The health of individuals in the facility would otherwise be endangered;</p> <p>The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or</p> <p>The facility ceases to operate.</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 82 residents.</p>	F 201			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 201	<p>Continued From page 1</p> <p>Based on interview and record review, the facility failed to discharge resident #1 with appropriate cause from the facility on 6/26/16.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The city Police Department Supplemental Offense Report, dated 6/26/16, documented the resident was arrested and incarcerated while out of the facility. The resident lived at the facility, which was for mentally challenged adults but had the ability to come and go as he/she pleased from the facility. When the police department dispatch attempted to contact the facility, they were unable to reach anyone at the facility by phone. A sergeant went to the facility and spoke with Licensed Nursing Staff G, who stated to the officer that the resident would not be able to return to the facility at this time, he/she understood what he/she was doing and he/she knew he/she was in trouble and was "playing off" as though he/she did not understand. <p>On 7/1/16 at 9:50 AM, during a call between the state agency and facility Administrative Staff A and Administrative Nursing Staff D, staff A stated the resident was no longer at the facility. When asked if this had to do with the fact that the resident had been arrested on 6/26/16 and remained incarcerated at this time, Administrative Staff A stated, "Yes, we discharged him/her". When asked if the facility had given a 30 day notice of discharge, Administrative Staff A stated, "No, they had done an immediate discharge based on the resident was a harm to him/herself and to others."</p> <p>Review of the Notice of Discharge, dated 6/26/16, provided by the facility documented the facility</p>	F 201			

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F 201	<p>Continued From page 2</p> <p>discharged the resident due to unacceptable behaviors. The resident's behaviors placed the resident's safety and welfare in danger as well as the resident's peers. It was determined that the facility could no longer meet the resident's individual needs. The notice failed to identify where the resident was discharged to.</p> <p>The facility provided letter, signed by practitioner consultant GG and dated 6/26/16, documented after a thorough review of the resident's behaviors, consultant GG determined that the resident not only put his/her own welfare at risk, but also the welfare of his/her peers in danger. Due to his/her unwillingness to comply with his/her plan of care and his/her risky/dangerous behavior it had been determined that the resident would be discharged immediately from the facility.</p> <p>The nursing note, dated 6/27/16 at 10:30 AM, (one day after the resident was arrested and incarcerated) documented the resident signed him/herself out of the facility at 8:00 AM on 6/26/16 indicating he/she was going to the store. At approximately 10:15 AM, a police officer arrived at the facility and informed the nurse that the resident had been arrested. The physician was contacted and received an order to discharge the resident.</p> <p>The social service note, dated 6/27/16 at 10:33 AM, (one day after the resident was arrested and incarcerated) documented the same information as the previous nurse's note and stated the resident had been discharged to the jail where he/she remained.</p> <p>On 7/13/16 at 2:05 PM, Administrative Nursing Staff E stated the resident behavior monitoring is</p>	F 201			

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F 201	<p>Continued From page 3</p> <p>all done by licensed staff in the treatment record, there is no other documentation of behaviors in the facility.</p> <p>Review of the May 2016 treatment record documented the following behavior monitoring documented daily by each shift, day/evening/night: For Geodon monitor for delusions, none noted. For Prozac monitor for isolation, none noted. For Trazadone monitor for sleeplessness, none noted.</p> <p>Review of the June 2016 treatment record, through 6/26/16, documented the following behavior monitoring documented daily by each shift, day/evening/night: For Geodon monitor for delusions, none noted. For Prozac monitor for isolation, none noted. For Trazadone monitor for sleeplessness, none noted. For Ativan monitor for pacing and rummaging, none noted. For Haldol monitor for delusions, none noted.</p> <p>The behavior monitoring for the resident, reviewed for May and June 2016, lacked identification or monitoring of any behaviors that would attribute to safety concerns or harm to self or others.</p> <p>Review of the clinical notes report for the resident, from 4/1/16 to 6/27/16, revealed the record lacked any documentation of behaviors that would attribute to safety concerns or harm to self or others.</p> <p>The physician's encounter note, by practitioner consultant GG, dated 6/15/16, 11 days before</p>	F 201			

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F 201	<p>Continued From page 4</p> <p>he/she wrote the letter to discharge the resident for risky/dangerous behaviors on 6/26/16, lacked any documentation or concern regarding behaviors by the resident.</p> <p>The behavior risk assessment, dated 1/28/16, documented the resident had no behaviors. The behavior risk assessment, dated 3/31/16, documented the resident had no behaviors except pacing and aimless wandering once or twice a week. The behavior risk assessment, dated 6/23/15, 3 days before the facility discharged the resident, documented the resident had no behaviors.</p> <p>On 7/13/16 at 11:31 AM, Administrative Nursing Staff D stated that all resident behavior monitoring is documented in the behavior flow sheet, which is part of the Treatment Record. Each resident is monitored for every medication they take on every shift. When asked when the resident first exhibited behaviors that were identified as at risk to others or him/her self, staff stated " When he/she broke into that ladies home (the incident on 6/26/16 that lead to the resident ' s arrest and incarceration). When asked to clarify that this was not at the facility, but rather when the resident was in the community, staff D confirmed that was correct. When asked if he/she had ever seen the resident exhibit behaviors in the facility that were or could be considered a threat to other resident ' s safety, staff D stated, " No. " When asked if he/she had ever seen the resident exhibit behaviors in the facility that were or could be considered a threat to him/her self, staff D stated, " Not that I can recall. "</p> <p>The clinical record lacked evidence to support the</p>	F 201			

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F 201	Continued From page 5 resident was a danger to him/herself and/or others. The discharge was inappropriate and did not meet requirements.	F 201			
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or	F 203			

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F 203	<p>Continued From page 6</p> <p>discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by:</p> <p>The facility reported a census of 82 residents. Based on interview and record review, the facility failed to provide adequate notice of discharge to resident #1 with no evidence of the resident's receipt of the discharge notice and no identification of the location to where the resident was discharged.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of the Notice of Discharge for resident #1, dated 6/26/16, provided by the facility documented the facility discharged the resident due to unacceptable behaviors. The resident's behaviors placed the resident's safety and welfare in danger as well as the resident's peers. It was determined that the facility could no longer meet the resident's individual needs. The notice failed to identify where the resident was discharged to. 	F 203			

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F 203	Continued From page 7 The social service note, dated 6/27/16 at 10:33 AM, (one day after the resident was arrested and incarcerated) documented the resident had been discharged to the jail where he/she remained. The statement provided by the facility, dated 7/11/16, documented on 6/27/16 Social Service Staff X faxed a letter stating the resident was being immediately discharged from the facility due to placing him/herself and others in danger. This letter was faxed to the county jail. A follow up call was made and a jail staff member acknowledged the receipt of this letter and stated he/she would review the letter with the resident. There was no evidence that the resident received or understood the discharge letter that was provided to the jail, not directly to the resident. On 7/13/16 at 11:31 AM, Administrative Nursing Staff D stated when asked when the resident first exhibited behaviors that were identified as at risk to others or him/her self, staff D stated "When he/she broke into that ladies home (the incident on 6/26/16 that lead to the resident's arrest and incarceration). When asked to clarify that this was not at the facility, but rather when the resident was in the community, staff D confirmed that was correct. When asked if he/she had ever seen the resident exhibit behaviors in the facility that were or could be considered a threat to other resident's safety, staff D stated, "No." When asked if he/she had ever seen the resident exhibit behaviors in the facility that were or could be considered a threat to him/her self, staff D stated, "Not that I can recall." The facility failed to provide adequate notice of discharge to resident #1 with no evidence of the	F 203			

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F 203	Continued From page 8 resident's receipt of the discharge notice and no identification of the location to where the resident was discharged on the discharge notice.	F 203			